

This ACR RADPEER™ Participation Agreement must be signed by the Radiology Chair/Medical Director (Facility Administrator) of the Department or Group. Original, electronic or faxed signatures are required on this form. Stamped signatures are not acceptable.



1891 Preston White Drive
Reston, Virginia 20191

RADPEER™ APPLICATION

Name of Practice/Facility: _____

Address: _____

Phone: _____ **Fax:** _____

Radiology Chair /Medical Director (Facility Administrator):

Facility Point of Contact (POC):

Phone: _____ **Fax:** _____

E-Mail: _____

Number of Radiologists in Group: _____

ACR RADPEER™

Please check one:

Academic Institution	
Hospital	
Free Standing Office	
Government/VA	

Please Complete:

Type/per year	Number
Plain Films/year	
Ultrasound exams/year	
CT scans/year	
MRI scans/year	
Mammograms/year	
Nuclear Medicine scans/year	
Interventional procedures/year	

Please check one:

# Physicians	Annual Fee	
2-5	\$600	
6-15	\$1300	
16-25	\$2000	
26-35	\$2800	
36-45	\$3600	
46-55	\$4400	
56-65	\$5200	
66-75	\$6000	
76-85	\$6800	

Check enclosed, made payable to ACR (Include RADPEER™ # on check, if available)

OR

Charge credit card VISA MasterCard American Express

Card No. _____ Exp. Date _____

Name of Cardholder: _____

Signature: _____

Please enroll

(name of facility/group)

in the ACR RADPEER™ program. I agree to submit the amount of

\$_____ for one year participation in the RADPEER™ program.

Please select one:

RADPEER™ (Paper version)

e RADPEER™ (Electronic Version)

Term of participation will begin on date your application is processed and will extend to the last calendar day of the twelfth month following this date.

Print Name

Signature

Date

Radiology Chair/Medical Director

I understand that all information received from my facility under the RADPEER™ program will be treated as privileged and confidential peer review and maintained in strictest confidence.

Please return the RADPEER™ application and fee to:

RADPEER™

ATT: Fern Jackson

1891 Preston White Drive

Reston, VA 20191

Phone: 703-715-3490 Fax: 703-295-6776

email: fjackson@acr.org

**** Make check payable to The American College of Radiology.**

For ACR office use only

Executed on _____, 20____

Expiration Date _____

ACR eRADPEER™, Program Manager